DENTAL CARE

QUESTIONNAIRE AND CONSENT FOR DENTAL TREATMENT DURING COVID-19 HEALTH CRISIS

Please read carefully and answer the following questions:

YES NO Do you have fever or have you felt hot or feverish recently (14-21 days)?

YES NO Are you having shortness or breath or other difficulties breathing?

YES NO Do you have a cough?

YES NO Do you have flu-like symptoms, such as gastro-intestinal upset, headache or fatigue?

YES NO Have you experienced recent loss of taste or smell?

YES NO Are you in contact with any confirmed COVID-19 positive patients? (Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment).

YES NO Do you have heart disease, lung disease, kidney disease, diabetes, or any other auto-immune disorders?

YES NO Have you traveled in the past 14 days to any regions affected by COVID-19?

YES NO I would like to have dental treatment by TNT Dental Care team. I understand my risks in the disclosure below.

DISCLOSURE:

You are receiving dental care during the events of COVID-19 National Emergency. Please be advised that there may be risks in being in the proximity of dentists, staff, and other patients. We are taking precautions to limit the spread of disease, yet there is still a possibility of transmission.

_____

Patient's Name Printed

_____ _____

Patient's Signature Today's Date